

Area Plan Objectives 2000-03
Progress Report 2000 - 2002

HOME CARE QUALITY

1. To advocate for increased worker wages and benefits in accordance with a livable wage standard. (December 2003)

Almost 200 people attended the Long Term Care Legislative Forum sponsored by the Advisory Council and partner organizations in October 2000. After small group discussions of six critical legislative issues including worker wages, participants voted on their top priorities for the 2001 State Legislative session. Then in the afternoon participants engaged in a dialogue with an panel of five key state legislators. ([see Attachment 1](#))

Advisory Council members and ADS staff participated in the W4A Lobby Days during the 2000 and 2001 State Legislative sessions. They advocated for increased worker wages with their representatives. In September and October 2002, the ADS Director and Advisory Council members conducted individual advocacy briefings with key legislators highlighting the worker wage issue.

2. Increase case management monitoring of clients who are served by individual providers who are relatives and at risk of poor care or abuse. (December 2001)

- Advocate with state legislators for adequate case management resources to enable case managers to conduct more home visits for high risk clients.

The 2000 Legislative Forum priority issues and discussion with state legislators included funding for a 75:1 caseload for case managers in order to increase contacts and improve quality of care.

- Increase contact to twice a year for high-risk clients.

State Case Management standards include new guidelines for increased contact with high risk clients for each of several caseload size scenarios.

3. Implement a training program for younger disabled individuals on hiring and supervising individual service providers (December 2000)

During 2000, a pilot study was implemented for the Personal Assistance Training (PAS). The pilot involved clients in the case management program. About 16 clients were referred to a WCCD trainer. Six agreed to participate, however only four completed the program. As a result of the training clients were able to successfully hire personal care assistants. Clients learned how to develop a job description, an employment ad, an employment agreement, and how to conduct

interviews. WCCD indicated that they are not willing to operate a PAS training program in the future. Instead the agency will focus on their Information and Assistance function, and the employment and travel training programs.

4. Increase monitoring of clients who are served by agencies. (December 2001)

- Improve turnaround time from referral to placement of home care aides in clients home by implementing a home care referral system that will allow case managers to electronically refer clients to home care agencies and to track agency performance. (December 2000)

The Home Care Referral system was implemented in 1999. All firewall issues related to Home and Community Services and case management subcontractors were resolved fourth quarter 2001. All ADS case managers have been trained to use HCR. Seventy percent of ADS case managers are active users. HCS case managers are being trained first quarter 2002. ADS staff are working with some home care agencies who continue to have technology issues. A final evaluation report measuring changes in turnaround time from baseline to post implementation will be completed in April 2002.

Real time reports are available to case managers and managers to monitor agencies referral acceptance rates ([Attachment 2](#)).

- Implement an electronic home care aide time tracking system that enables workers to use the telephone to check in and out when they are working at a client's home. (December 2001)

The HCATT system began rolling out in December 2000. The interactive voice response system has been tested and is in operation. Home care agencies are receiving training, worker data is being uploaded to HCATT, and system rollout will be completed by third quarter 2002.

- Give case managers real-time access to time tracking system so that they can be immediately notified of any service gaps. (December 2001)

Case managers have access to the HCATT system which has been integrated with the HCR (home care referral system). Once the HCATT rollout is completed with home care agencies, case managers will have real time data to help them track service to their clients.

- Incorporate performance-based measures and employee turnover rates in home care agency contracts. (January 2000)

Performance-based measures were incorporated in home care agency 2001 contracts. Employee turnover rates will be tracked through the HCATT system which includes home care worker data.

HEALTH

1. To increase by 5% the number of older residents throughout Seattle and King County who improve their health status and quality of life by participating in health promotion and lifelong enrichment activities. (December 2001)

Access

- Increase the number of County human services subregions that offer a minimum set of culturally and linguistically appropriate health promotion services.

No progress to report.

- Increase the number of refugees who participate in health promotion activities by coordinating outreach efforts with mutual assistance associations.

ADS received a grant from the Office of Refugee Resettlement for \$125,000 starting October 2001 to develop and implement nutrition / health promotion activities in three refugee communities: Lao/Hmong, Ukrainian, and East African. Outreach / Trainer staff have been identified for two communities. ADS is working with the communities to develop a health promotion curriculum that will cover the issues of fall prevention, depression interventions, the need for immunizations, and physical activity among others.

- (New) Support the development, design and implementation of the 211, a coordinated community information and referral telephone access system for Washington State citizens.
- Develop resources through advocacy efforts at state and federal levels, grant writing, or allocations processes to fund services in county subregions that do not have a minimum set of health promotion services.

No progress to report.

- Develop opportunities for access to a broad range of health promotion areas including recreational, educational, and cultural activities.

No progress to report.

Transportation

- (New) Work with providers such as senior centers, nutrition sites, outreach providers, senior wellness sites to develop five sites as transfer points for King County Metro ACCESS.
- ~~(Delete) Work with King County Metro Access transportation to develop trip planning positions stationed in each county subregion to minimize trip costs and increase the number of people who have access to services. (Rationale: No longer feasible given current funding climate)~~
- ~~(Delete) Reduce the time it takes to schedule a ride by working with Metro to make on-line trip scheduling available to trip planners and service participants. (Rationale: This objective is being accomplished by Metro without the need for ADS involvement.)~~
- Support increased Metro funding to replicate the Des Moines/Normandy Park Senior Transportation Program.

Funding is now provided in Metro budget to Senior Services. No increases are envisioned due to County budget cuts.

- Advocate for Metro funding to expand volunteer transportation which includes hand-to-hand service.

During 2001 Metro provided funding to Senior Services for five Transportation Coordinators, and a .5FTE clerical position to expand volunteer transportation. Plans to co-locate Senior Services staff with Metro staff, and underwriting of more operational costs will be implemented during 2002.

Quality

- Implement self report measures for quality of life and health status in health promotion and nutrition services.

No progress to report.

- Seek resources to partner with natural medicine experts to implement documented health promotion and nutrition approaches based on natural medicine.

No progress to report.

- (New) Create a medical advisory committee to systematically strengthen relationships and communication between ADS (case management in particular) and health providers (i.e. Doctors, Nurses, Geriatricians, etc.)

Technology

- Develop a web-based map of existing health promotion services funded by Seattle Library, Seattle-King Public Health Department, Aging & Disability Services, Seattle Housing Authority, and Seattle Parks Department.

Electronic inventory of existing health promotion services is complete. Development of a web-based mapping application using SVG and AxiMap is in progress.

- Develop a map of existing health promotion services available in King County.

See response above.

- Increase by 5% the number of family caregivers, clients, and staff who access the web-based resource sites.

Senior Information & Assistance, Crisis Clinic, and Kin On Healthcare Center established in-take fields for all new calls/web hits occurring for family caregiver related queries. This was made possible through both new State and Federal Caregiver allocations. Baseline data was gathered in the beginning of the respective contracts with these agencies and further reports from them will help us ascertain an actual percentage increase.

- Train library, parks, health department, and housing authority staff to access information through resource web sites created by Information and Assistance, Seattle Public Access Network, and King County.

No progress to report.

- Create links to King County Metro on-line information sources for both fixed route and ACCESS. Educate trip planners and riders to make best use of on-line trip planning tools.

King County METRO currently has launched “on-line” trip planning for the fixed and ACCESS routes.

Intergenerational Initiatives

- Seek resources to establish and test the effectiveness of systems for training, mentoring, and providing technical assistance to senior and youth partners who are interested in increasing computer skills.

During 2001 an ADS Americorps volunteer coordinated a Computer Pals Program. The program matched seniors with middle and high school students who helped seniors develop computer skills.

- (***Revised***) Increase by up to 600 (200) the number of senior volunteers who will be matched with youth from Seattle Public Schools for mentoring, tutoring, and arts and culture projects, computer pals, and intergenerational dialogues. (December 2001)

During 2000-01 there were 207 new volunteers involved in the Seattle Public Schools through the SPICE program.. Of these approximately 142 seniors (unduplicated) established primary intergenerational relationships. These activities included mentoring, tutoring, and small & large group activities such as computer pals, cooking/nutrition classes, reading out-loud activities, math activities, and sewing & art projects.

- (***Delete***) ~~Seek resources to support educational programs and services that address the local needs and concerns of grandparents raising grandchildren. (Completed)~~

ADS received \$50,000 from the National Family Caregiver Act funding for support for kinship care. Four subcontractors are providing media resources, brochures, education and support to grandparents raising grandchildren.

Also in the City of Seattle Consolidated Plan, ADS revised language related to eligibility for nutrition services to include grandparents 50 and over and their grandchildren.

- (***New***) Fund grandparent support programs to enhance services for grandparents raising grandchildren.
- Advocate with statewide task force to work on changing state laws that create barriers for grandparents raising grandchildren.

ADS advocated with the Governor to extend TANF five-year time limits for Kinship Care families. ADS also proposed possible amendments to existing state Family Caregiving legislation (a.k.a., Rep Edmonds' legislation) and use of the Oregon Cares non-categorical Respite legislation as models, which might allow use of

State and National Respite funding to grandparents needing Respite Child Care.

Nutrition Initiatives

- Increase fruit and vegetable consumption among 15% of regular meal program participants.

In 2001 ADS pilot tested the Senior Farmers' Market Nutrition Program (SFMNPP) to enhance access to fresh fruits and vegetables for 500 homebound seniors and supporting sustainable agriculture in Washington State.

The SFMNPP was successful in its goal to increase the fruit and vegetable intake of homebound seniors in King County, Washington. A quantitative fruit and vegetable intake survey was administered by phone to 87 SFMNPP participants and 44 representative controls before and during the last month of the basket deliveries. The following are the main survey findings.

- ***At baseline, only 22% of future program participants reported eating five or more servings per day. As a result of program participation, this percentage increased to 39%.***
- ***Within the intervention group, daily consumption of fruits and vegetables increased by 1.04 servings per day. Within the control group, daily intake decreased by 0.27 servings per day. This difference is significant at $p < .0001$ (CI 0.68-1.95).***
- ***An overwhelming majority (94%) of program participants reported that they would like to participate in the SFMNPP in the future.***

To gain a detailed understanding of the impact of the program, 27 of the participants were interviewed in their homes. A number of common themes were discovered, such as:

- ***program participants appreciated the quality and variety of the fresh fruits and vegetables***
- ***many participants would not have had access to fresh fruits and vegetables without the program***
- ***the program improved quality of life and brought joy into the lives of the participants by giving them the gift of fresh fruits and vegetables***
- ***participants enjoyed the program newsletter and appreciated the fact that the produce was all locally grown***

ADS is planning to expand the Market Basket Program to include 1000 seniors in 2002 including homebound and congregate meal participants.

- Decrease food insecurity by increasing participation of seniors below 200% of poverty level in senior nutrition programs.

A new congregate meal program serving East African seniors began in 2001. Over 40 low-income seniors are served each month from 5 ethnic groups: Tigray, Ethiopian, Somali, Oromo, Gondar. Plans are in place to start a new congregate meal program serving at least 60 low-income Ukrainian refugees in early spring 2002.

From June through November 2001 ADS added the senior market basket delivery for 500 low-income homebound seniors. The project evaluation showed a significant increase in servings of fruits and vegetables consumed by market basket participants. ADS plans to add 300 low-income elders in ethnic communities to the senior market basket program assuming adequate levels of funding from the USDA SFMNP program.

2. To increase by 10% the number of older people in King County who are aware of disease prevention measures which they can take to reduce depression, increase immunity to influenza and pneumonia, increase their physical activity, and prevent falls. (December 2002)
 - Participate in the Healthy Aging Partnership, a coalition of aging organizations sponsored by Public Health: Seattle-King County.

2000 – 2001 Data

HAP ACTIVITIES	MAY TO DEC., 2000	JAN. TO JUNE., 2001
1-888-4ELDERS Calls	1,491	1,943
HAP Website Hits	8,600	17,300

2001 Senior Information Campaign Activities

Radio Ads - Produced 60-second radio ads to conduct a four-week paid advertising campaign promoting 1-888-4ELDERS on KIXI, KVI, and KOMO. The campaign also included 15-second underwriting announcements on KUOW (NPR). The radio advertising effort resulted in a 70% increase in calls from May to June 2001.

Brochures - Partnered this summer with the Washington State Department of Health to print and distribute brochures on physical activity for seniors to more than 400,000 households in King, Kitsap, Pierce, and Snohomish counties. The brochures were mailed directly to 100,000 senior households. Another 285,000 brochures are scheduled to be inserted in community newspaper and senior publications in early August, while HAP partners will distribute

30,000. Produced and distributed more than 65,000 brochures promoting the number in Spanish, and Asian languages.

News Releases - Published monthly columns in Northwest Prime Time News, a 50,000-circulation publication in King County, on topics including fall prevention, immunizations, physical activity, home care, support groups, dental health, strokes, hypothermia, and dealing with the death of a spouse. Distributed the columns as news releases each month to 60 community newspapers.

Other Activities – Included flyers promoting 1-888-4ELDERS and fall prevention tips in property tax mailings to 280,000 King County households in February 2001. Another 20,000 refrigerator magnets and 150 posters were also distributed promoting the new number. Produced and displayed interior bus ads promoting 1-888-4ELDERS in 75% of Metro bus routes covering King, Pierce and Snohomish counties.

- Educate bilingual outreach staff who serve refugee elders about fall prevention, depression interventions, the need for immunizations, and physical activity (Dec 2001).

ADS received a grant from the Office of Refugee Resettlement for \$125,000 starting October 2001 to develop and implement nutrition / health promotion activities in three refugee communities: Lao/Hmong, Ukrainian, and East African. Outreach / Trainer staff have been identified for two communities. ADS is working with the communities to develop a health promotion curriculum that will cover the issues of fall prevention, depression interventions, the need for immunizations, and physical activity among others.

3. To increase by 5% the number of case management clients diagnosed with diabetes whose disease is under control. (December 2003)

Baseline Data

Clients By Race	Total CMP Clients		CMP Clients With Diabetes		High Risk on Registry	
	#	%	#	%	#	%
White	2,402	67%	529	22%	114	62%
Af/Am	837	23%	198	24%	44	24%
A/PI	49	1%	23	47%	7	4%
Hisp.	85	2%	31	36%	9	5%
Nat/Am	70	2%	20	29%	3	3%
Other	132	4%	15	11%	7	4%
Total	3,575	100%	816	23%	184	23%

Interventions

There will be three interventions with high-risk clients, already proven to be effective in controlling diabetes. The medical nutrition therapy and the physical activity/exercise components were implemented in April 2001. To date, approximately 45 clients have received these interventions.

Nutrition - A Registered Dietitian is conducting home visits throughout the county to assist clients with evaluating and modifying their diets and nutritional needs.

Physical activity/exercise - UW Physical Therapy graduate students conducted interviews and assessments with CMP clients age 60 and over who reside in Seattle. The assessment results are being used for the development of a Readiness to Exercise Assessment form. The assessment will be pilot tested in Spring 2002.

Medication management - The medication management intervention will be implemented in 2002.

Diabetes Registry - Client data is maintained in the ADS diabetes registry, (a.k.a. Diabetes Electronic Management System (DEMS). The registry maintains important medical information (HbA1C) and tracks the progress, status and completion of each intervention strategy.

Partners

ADS has partnered with the following organizations for the Diabetes Project:

- ***ADS subcontracted agencies (ACRS, CISC) for future program expansion.***
- ***Comprehensive Health Education Foundation (CHEF) for the physical activity/exercise.***
- ***Public Health: Seattle-King County for medical nutrition therapy.***
- ***UW Medical Center for the physical activity/exercise assessment tool.***
- ***UW Department of Rehabilitative Services for the physical activity/exercise client assessment/evaluation.***
- ***Racial and Ethnic Approaches to Community Health (REACH) for the Coordinator position.***

Funds

Funds for the project have been provided by:

- ***ADS discretionary funding, \$24,000***
- ***CHEF funding, \$7,500***
- ***REACH funding, \$21,580***

4. To test the effectiveness of problem-solving therapy in alleviating symptoms of depression with 250 older people who receive case management assistance or participate in the African American Elders program in partnership with University of Washington. (December 2003)

The UW Health Promotion Research Center is collaborating with ADS and other community agencies in the Seattle area on a study aimed at reducing minor depression among older adults. Specifically, ADS has assisted with identifying potential clients who are 60 years of age and older who are at risk for depression.

During 2001, the recruitment goal was reduced from 250 to 150 because statistical calculations indicated that would be enough to show if the program is effective. The project also received 1,341 recruitment screeners, and 920 were from ADS. Of the 920, 142 completed eligibility interviews, and 52 were found to be eligible and are in the study. As of December 2001, a total of 113 participants were enrolled in the study (57 in the intervention group and 55 in the control group). ADS staff are still serving as two of the three interventionists. Case managers are no longer actively recruiting clients; however, they will continue to help with recruitment through first quarter 2002, through letters sent to new clients and to clients living in some zip codes outside our immediate catchment area. Outcome data is not yet available, but analyses of preliminary data support the effectiveness of PEARLS intervention.

Characteristics of the study subject are as follows:

<i>Females</i>	<i>79%</i>	<i>Married</i>	<i>19%</i>
<i>Caucasian</i>	<i>52%</i>	<i>Divorced</i>	<i>30%</i>
<i>African American</i>	<i>38%</i>	<i>Widowed</i>	<i>46%</i>
<i>Hispanic</i>	<i>2%</i>	<i>Single</i>	<i>5%</i>
<i>Asian</i>	<i>4%</i>	<i>Disabled</i>	<i>58%</i>
<i>Other</i>	<i>3%</i>	<i>Average age</i>	<i>73.8</i>

LONG TERM CARE

1. To increase by 5% the average length of time adults with functional limitations who need long term care are able to stay in their homes without the need for higher levels of care. (December 2003)

Baseline data was gathered for 2000. The data indicated that of the 5,347 case management program clients, the average length of time clients stay at home was 19 months.

- Increase nurse consultation with case management clients who have the highest health risks.

Baseline data collected for 2000 demonstrated that nurse consultations with high-risk clients were as follows:

In office consults between case managers and nursing services – 2,317

Phone consultations – 1,075

Field visits – 442

Unduplicated client count - 462

- Increase by 10% the number of home care workers serving clients in areas in which there is a shortage of workers (e.g., East King County) by developing a plan with King County METRO to fund van lease options that will enable home care agencies to transport workers to areas with high demand for service.

Implementation of the Home Care Aide Time Tracking system began in December 2001. Home care aide information loaded into the system in January 2002 will be used to generate baseline data for location of home care workers versus demand for home care by region.

ADS has convened a bimonthly Transportation Workgroup with key stakeholders in the area of transportation to address obstacles including the home care worker shortage in East King County.

- Increase by 10% the number of Hispanic people with functional limitations who access case management services.

A case manager was co-located in the Latino Information and Assistance office part-time. During 2000, approximately 295 Hispanic case management clients received assistance.

- Increase by 10% the amount of funds for younger disabled case management clients to purchase goods and services not covered by Medicaid.

The Fund amount at the end of 2000 was \$571, compared with the 2001 amount of \$3,666. This is a significant increase of 542 percent!

2. To test on a pilot basis the effectiveness of linking primary and long term care with funding and services for an enrolled group of clients. (December 2003)

In a Memorandum of Understanding with Chinese Information Service Center (CISC), Aging and Disability Services (ADS), and Aging and Adult Services Administration (AASA), Kin On Community Care Network will carry out an innovative service that provides a continuum of social, medical, and supportive services. The services are linguistically and culturally sensitive and meet the needs of Chinese and other Asian elderly and disabled community members as they age.

The first year consisted of an alignment of Kin On's current services tied together into a network of services to meet needs of individual and disabled elders. The services include home care, home health, bi-lingual lifeline, family caregiver support, health promotion, information, education, and a skilled nursing facility. The service network priorities include developing a common data system, procedures, processes, central intake, staff coordination and training.

During the second year Kin On will develop a partnership with CISC, refine the care network processes, and begin serving clients. The two agencies will coordinate and collaborate to determine agency roles, responsibilities, protocols, and assure the Care Network clients receive high quality services. It is expected that Kin On will serve approximately 10 clients between July 1, 2001 and April 1, 2002, or an average of 5 new clients per quarter, beginning January 1, 2002.

ADS submitted a grant request to Robert Wood Johnson Foundation on behalf of the Healthy Aging Partnership to further planning efforts to link primary and long term care in King County. The proposal was not funded, and ADS is continuing to look for funding sources.

ADS submitted a response to the Request For Information from the Medical Assistance Administration which is seeking to fund approaches that link primary and long term care in an attempt to reduce acute care service utilization costs.

ADS is investigating funding possibilities to test the use of the Health Buddy internet appliance in the case management program for groups of clients with chronic diseases such as diabetes, asthma, heart problems, etc. The Health Buddy is one component of the Health Hero service which connects healthcare providers, payers, and product suppliers to patients at home, enabling a means for cost effective daily patient support and monitoring.

The Health Hero Technology Platform consists of the Health Buddy® appliance and the Health Hero® iCare Desktop.

- ***Patients use the Heath Hero Health Buddy Personal Information Appliance, an easy-to-use appliance that plugs into a patient's existing phone line, to view information from their care provider. Patients respond to daily queries about symptoms, behavior and knowledge.***
- ***Information collected from patients is stored in the Health Hero® data center where authorized care providers can view it over the web.***
- ***Care providers use the Health Hero iCare Desktop to view current or historical patient information, trend graphs, or reports. The Health Hero service includes notification features so care providers will be alerted if a patient's response falls outside a parameter they have specified. Patient diagnosis and treatment is determined and administered solely by a healthcare professional.***
- ***Provider-patient dialogues are available to meet the specific needs of an organization. Dialogues can be developed for any conditions in which on-going communication with patients would be beneficial, for example asthma, diabetes, congestive hearth failure, co-morbid conditions or general wellness. Care providers control the content, how often patients receive information, and the parameters for notification and alert features.***
- ***Care managers are able to increase their productivity, even with daily patient monitoring, three to four times over their previous, weekly, telephonic patient monitoring.***

Substantial outcomes analysis from customers using the Health Hero Network showed:

CHW - Health Hero enhanced CHW CHAMP program, as compared to standard care, which showed further reductions in total direct-variable costs to a total of \$9,151 PPPY. Hospitalizations and ER visits were reduced by 73%. Total bed-days were reduced by 80%.

Pacificare - The outcome analysis showed inpatient hospitalizations were reduced by 50% and ER visits by 73%. Costs for hospitalizations and ER visits were reduced by 50% and total savings in claims paid of \$5,271 per member per year were realized.

VISN 8 - VISN 8 results for their six-month, 600 patient study showed a 74% cost reduction in areas such as inpatient, outpatient and medication costs. Utilizing the Health Buddy in six diseases ranging from CHF to mental health, this translated to a net savings of 23 million dollars across the study population, over half of which communicated

with caregivers via the Health Buddy® Appliance. Patient's reported they were more educated, more secure and better able to manage their own health care needs.

HOUSING

1. To secure housing with Section 8 vouchers for up to 30 younger disabled case management clients living in King County. (December 2000)

- Partner with nonprofit agencies to develop project-based Section 8 housing for disabled adults.

Work on this objective far exceeded the original target. As of the end of October 2001, a total of 115 households were referred to the HASP. Of these, 80 have received housing vouchers. Ten unduplicated households are receiving housing search assistance through the YWCA. Approximately 59 households have entered into housing lease agreements.

- Partner with King County Metro to assess the physical location of potential project-based Section 8 sites.

Brokered an agreement between HopeLink and Evergreen Care Center for an application to King County Housing Authority for ten Project-based Sec. 8 Housing vouchers at the new *Village at Overlake Transit Station*, (The first model of Transit-Oriented Development like this in the Nation). These vouchers also include two years of free Metro bus passes for residents. All units are ADA accessible.

- (~~Delete~~) Pilot test cluster care at one site for younger disabled people. (Rationale: Cluster care projects are not feasible due to HCFA rules related to client choice of home care providers.)

2. To increase by 5% the number of affordable housing units with services to support aging in place in one rural area that has the greatest need. (December 2003)

No progress to report.

- Partner with non profit developers to coordinate an affordable housing project with services.

No progress to report.

3. To increase by 5% the average length of stay of older adults who live in subsidized housing sites prior to needing higher levels of care. (December 2003)

- (~~**Delete**~~) ~~Pilot test cluster care for multiple residents receiving home care at one site. (Rationale: Cluster care projects are not feasible due to HCFA rules related to client choice of home care providers.)~~
- (~~**Delete**~~) ~~Develop building-based case management at the pilot site. (Rationale: This objective is a companion with the cluster care objective that is no longer feasible.)~~
- Pilot test the integration of Medicare and Medicaid services to eligible residents including innovative ways to support transportation services to both.

Developed, with the *Healthy Aging Partnership*, a Robert Wood Johnson application for a King County demonstration project of an “*Integrated Care Model*”. This was not funded.

- Carry out eviction reduction strategy to ensure that 80 percent of Seattle Housing Authority high rise and SSHP residents who receive eviction notices will retain their housing.

No progress to report.

- Expand wellness programs to at least six King County Housing Authority sites.

No progress to report.

- Advocate for continued HUD funding for subsidized units available to older adults and adults with disabilities, taking into consideration access to existing King County Metro fixed route and ACCESS programs.

Advocated with HUD to encourage, through their funding processes, special financial support for units that are “*Universally Designed*”, enabling better access to clients with disabilities.

4. (~~**Delete**~~) ~~To secure funding to increase Homesharing matches by up to 30 older adults in Seattle and up to 90 older adults in King County. (December 2003) (Rationale: Given the current funding climate for county resources, this objective is no longer feasible.)~~

5. **(New)** Educate major City and County housing funders, and other influential agencies regarding Universal Design (for new development and housing modifications) in order to increase housing stability for older people and adults with disabilities.
6. **(New)** Develop a Central Resource for Information regarding Universal Design.
 - Create City and County Universal Design resources for new multi-family, residential, and home modifications.
 - Create access/links through ADS website, and Information and Assistance sites.
 - Resources will target architects, housing developers, contractors, as well as print and media resources.

FAMILY CAREGIVERS

Family Caregiver Outcome: ~~(Delete)~~ Increase informed choices for families and people in need of long term care now or in the future. **(New)** Increase information, support and assistance for unpaid caregivers regarding their own needs and the needs of those for whom they are caring. **(Rationale: New Caregiver resources more clearly define desired outcome.)**

1. To increase by 5% the number of family caregivers who receive supportive information that guides their long term care choices (Dec. 2003).
 - ~~(Delete)~~ Develop report card (on line and brochure) based on state inspections of residential facilities (nursing homes, adult family homes, assisted living, etc.), complaints to the long term care ombudsman program, and performance reports for home care. **(Rationale: Information is already online.)**
 - Develop and evaluate the effectiveness of a marketing campaign to heighten family caregiver awareness of and ability to evaluate long term care options.

Please refer to list of funded projects below.

- Seek resources to implement training for financial, retirement, and long term care planning for older adults and caregivers.

No progress to report.

- Increase support for family caregivers.

See attached list of caregiver funding awards. These awards will provide the following core services:

NATIONAL FAMILY CAREGIVING SERVICES		
AGENCY (For services, please contact the Agency web site.)	PROJECT DESCRIPTION	CONTACT (For program information, please use this contact.)
Senior Services www.seniorservices.org	<p>Provide the main entry point for Caregivers who are caring for adults with disabilities and who are age 60 or older; as well as, Kinship Caregivers who are age 60 or older and caring for children under age 19.</p> <p>Information, Referral and Assistance Services through the Senior Information & Assistance call centers.</p> <p>Extend the access hours for I & A calls.</p> <p>Provide the lead coordination for all the Caregiver providers in King County, including hosting the NFCSP kick-off event for King County.</p> <p>Develop a comprehensive media campaign and a community outreach effort in collaboration with the Healthy Aging Partnership (HAP), which uses the easy-to-remember <u>1-888-4Elders</u>. Outreach will be conducted primarily through 40 congregate meal sites, 35 Senior Rights Assistance sites and 9 Senior Centers, countywide.</p> <p><u>Caregiver Specialists will:</u></p> <ul style="list-style-type: none"> ➤ Identify caregivers through community outreach, education and coordination with other providers. ➤ Cross train Outreach and Information Specialists who in turn will <ul style="list-style-type: none"> ➤ Provide direct service to caregivers on site. ➤ Use laptop computers to access the comprehensive resource database in order to assist caregivers in accessing services, etc. ➤ Provide limited in-home assistance. ➤ Conduct community and workplace educational workshops for caregivers. <p>Develop additional Caregiver components for the Senior I & A library.</p> <p>Enhance the Caregiver web site.</p> <p>Develop an interactive web page: <i>"Caregiver Journal Exchange"</i>.</p> <p>Provide a range of "Supplemental Services" such as transportation, home modifications, assistive devices, medical equipment, financial help for non-covered prescription costs, etc.</p>	Eileen Murphy eileenM@seniorservices.org
Crisis Clinic www.crisisclinic.org <small>Both State and Federal funding enables them to serve Caregivers who care for persons, age 18 or older.</small>	<p>Provide the main entry point for Caregivers caring for adults with disabilities, age 18 or older.</p> <p>Information, Referral and Assistance Services through the Community Information Line (CIL), 24-hour access, seven days a week.</p> <p><u>Caregiver Program Specialist will:</u></p> <ul style="list-style-type: none"> ➤ Trains all the "I & R" specialists regarding Caregiver needs and services. ➤ Provides in-person Caregiver Support. 	Julie Johnson jjohnson@crisisclinic.org

NATIONAL FAMILY CAREGIVING SERVICES		
	<p>➤ Arranges for Emergency Respite Care, when necessary.</p> <p>Develop and maintain a Caregiver website.</p> <p>Provide callback telephone support to caregivers.</p> <p>Continue Caregiver outreach and publicity.</p>	
<p>Kin On Family Support Center</p> <p>www.kinon.org</p> <p><small>Both State and Federal funding enables them to serve Caregivers who care for persons, age 18 or older.</small></p>	<p>Expand the outreach to community groups, Chinese religious groups, and other gatekeepers.</p> <p>Train volunteer caregivers recruited through Care Team ministries in basic caregiving techniques, how to access services, and support of family caregivers.</p> <p>Develop a training manual for Chinese Caregivers.</p> <p>Evening and Weekend coverage for Kin On supervisors available to caregivers and service providers (8:30 AM – 9:00 PM, seven days a week).</p> <p>Develop a bilingual Caregiver's web site (Chinese & English).</p> <p>Collaborate with City of Bellevue, Overlake Hospital and other Eastside providers to organize an Asian Caregivers Health Awareness Conference.</p> <p>Initiate an Asian Caregiver Alliance for King County that will plan a Caregiver Conference, develop Caregiver training curriculum and advocate for needs of Caregivers.</p>	<p>Catharine Wu</p> <p>catharinewu@kinon.org</p>
<p>Chinese Information Service Ctr.</p> <p>www.cisc-seattle.org</p>	<p>Outreach to potential Chinese caregivers through home visits, meetings with Chinese Associations, business and church groups. Special outreach efforts will be made in East King County.</p> <p>Care management support.</p> <p>Respite Promotion and Placement.</p>	<p>Stephen Lam</p> <p>stephen@teleport.com</p>
<p>Overlake Hospital</p> <p>www.overlakehospital.org</p>	<p>Outreach to informal support networks through the Eastside churches.</p> <p>Expand distribution of Caregiver materials developed for the Eastside.</p> <p>In-home counseling to family caregivers in Bellevue, Redmond, Mercer Island, Issaquah, Sno-Valley and North Bend.</p> <p>Develop a Bellevue-based Caregiver support group</p>	<p>Debbie Anderson</p> <p>danderso@overlakehospital.org</p>
<p>Alzheimer's Association</p> <p>www.alzwa.org</p>	<p>Outreach to unpaid caregivers of persons with Alzheimer's.</p> <p>A "Care Consultant" will establish a relationship with families caring for a person with Alzheimer's and develop a needs assessment.</p> <p>Develop a "care plan" with both short and long term goals, and provide on-going problem solving and follow-up with families.</p>	<p>Mark Buckley</p> <p>mark.buckley@alz.org</p>
<p>Professional Registry of Nursing</p> <p>www.prninc.net</p>	<p>Provide training for unpaid caregivers, when slots are available, for each of the Training programs available to paid caregivers.</p> <p>Provide special training for unpaid caregivers through the "Taking Care of You: Powerful Tools for Caregiving".</p>	<p>Jerry Crosby</p> <p>jlcrosby@prninc.net</p>
<p>Interfaith Volunteer Caregivers</p> <p>www.providencemarianwood.org</p>	<p>Recruit and Train new Volunteer Caregivers in order to increase the number of community residents who may be served.</p>	<p>Sally Farrell</p> <p>sfarrell2@providence.org</p>

NATIONAL FAMILY CAREGIVING SERVICES		
d.org	Trained Volunteers will provide assistance with transportation, shopping, errands, light housekeeping, companionship, short respite care and yard work.	
Eastside Adult Day Services www.eadsdayhealth.org	Develop a support group for caregivers in the Greater Issaquah and Sammamish Plateau communities. Develop a caregiver resource center at the Sammamish Plateau site, which can be used independently or with consultation from a trained staff member.	Paula Hardy pdhardy@serve.net
Evergreen HealthCare www.evergreenhealthcare.org	The Geriatric Regional Assessment Team (GRAT) will provide therapy services, (one to five sessions between 45 and 75 minutes) to isolated caregivers that are unable to access mental health services elsewhere. They will focus on high stress, depression, abuse or domestic violence, grief from the loss or decline of loved ones.	Karen Kent kkent@evergreenhealthcare.org
Northshore Senior Center www.halcyon.com/senior	Expand current support groups to include the Kirkland Senior Center. Extend the Health Enhancement Program (HEP) to caregivers in order to increase support for caregivers. Caregiver training: two series of six week classes on <i>"Taking Care of You: Powerful Tools for Caregiving"</i> . Counseling and emergency consultation for caregivers in a state of chronic or acute distress.	Marianne LoGerfo marianneL@seniorservices.org
King County Housing Authority www.kcha.org <small>State funding enables them to serve Caregivers who care for persons, age 18 or older.</small>	Coordinated Caregiver services for residents and caregivers in the 23 King County Public Housing residences. Individual consultations, including assistance with problem solving and decision making related to caregiving roles. Provided by the Support Services coordinators, including referrals to support groups, respite care and the Community Information Line (CIL) at Crisis Clinic, which provides 24-hour access to caregivers. Meetings at each of the 23 KCHA residences for caregivers; informational and resource mailings provided in all the major languages including Russian, Vietnamese and Korean.	Cassandra Miller CassandraM@KCHA.org
KINSHIP CAREGIVING (Grandparents and other relatives, age 60 or older, caring for grandchildren)		
Children's Services of Sno-Valley www.cssv.org	Develop a local media campaign, brochure to do outreach and recruitment in the Snoqualmie Valley, North Bend and Duvall areas of King Co. Assess the needs of current and new participants. Assist in accessing information, referrals to professional services such as legal. Assist with funds for individual family needs; i.e., summer camp, school break activities, supplies, athletic costs. Provide Kinship Caregiver support groups. Provide Child support groups.	Nancy Whitaker nwhitaker@cssv.org
Southeast Youth & Family	Provide an evening support group.	Jeri White

NATIONAL FAMILY CAREGIVING SERVICES		
Serv. www.scn.org/civic/seayouth	Workshops on a variety of specific topics unique to Kinship Care providers, such as Finance and Budget, Respite and Child Care, Child Development, Raising mixed race children, health, legal, nutrition, domestic violence, signs and symptoms of drug use, stress management, etc. Outreach and care management to assist kinship caregivers in accessing necessary services. Referrals to counseling, medical, housing, etc.	irwhiteseyfs@uswest.net
Atlantic Street Center www.atlanticstreet.org	Provide professionally facilitated therapeutic adult support groups and children's social skill groups. Educational workshops on adoption; custody and guardianship; healthcare and nutrition; economic and financial concerns; navigating the school systems; parenting issues unique to kinship care providers.	Tamsen Spengler tamsens@atlanticstreet.org
Public Health – Seattle & King Co. www.metrokc.gov/health	Identify and expand services to grandparents and other kin. Provide individual counseling for grandparents, with special emphasis on mental health issues and learning disabilities. Provide "system navigation" assistance for barriers in the health, education and TANF ("welfare") systems.	Abbey Moon-Jordan abigail.moon-jordan@metrokc.gov
<u>MINI-GRANTS</u>		
<u>U. of Washington Alzheimer Satellite.</u> <i>Both State and Federal funding enables them to serve Caregivers who care for persons, age 18 or older.</i>	<u>Organize and facilitate two (2) discussion groups for Chinese-American caregivers on shared experiences and needs to determine the desired services as well as the barriers experienced by these caregivers in accessing services.</u>	<u>Judy Cashman</u> judym@u.washington.edu
<u>Providence Mount Saint Vincent</u> www.providence.org/themount <i>Both State and Federal funding enables them to serve Caregivers who care for persons, age 18 or older.</i>	Plan and sponsor a one-day workshop for up to 150 unpaid caregivers of functionally disabled adults 18 years and older. It will provide life-enhancing strategies and information to improve the caregiver's quality of life.	<u>Carol Collins</u> cscollins@providence.org
<u>Magnolia Adult Day Center</u> <i>Both State and Federal funding enables them to serve Caregivers who care for persons, age 18 or older.</i>	Provide additional counseling and support to caregivers.	<u>Vanessa Harrold</u> 206-283-0233
<u>Korean Women's Association</u> www.kwaonline.com <i>Both State and Federal funding enables them to serve Caregivers who care for persons, age 18 or older.</i>	Plan and sponsor two educational seminars for unpaid Korean caregivers in the Federal Way, Auburn and Kent areas. The focus will be on alternative ways to strengthen the quality of caregiving for elders and adults with a disability.	<u>Faaluaina Pritchard</u> luaprkw@nwlink.com
<u>Mt. Si Senior Center/Snoqualmie Valley</u> <i>Both State and Federal funding enables them to serve Caregivers who care for persons, age 18 or older.</i>	Produce a brochure featuring local service providers who assist unpaid caregivers of adults with disabilities. It will be widely distributed, including the Snoqualmie Valley Caregivers Fair.	<u>Ruth Tolmasoff</u> tolmas@accessone.com

